114CSR64
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 64

MENTAL HEALTH PARITY

Section

114CSR64
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 64

MENTAL HEALTH PARITY

§114-64-1. General.

1.1. Scope. -- a. The purposes of this rule are to:

1. Create a legal framework within which insurers can develop an environment of parity between mental health and medical-surgical benefits;

2. Provide for parity in the application of aggregate lifetime limits, and annual limits, between mental health benefits and medical-surgical benefits;

3. Define standards by which health care professionals shall implement parity;

4. Minimize the possibilities of confusion and interruption of patient care; and

5. Ensure that cost containment measures not applicable to medical-surgical benefits are also not applicable to mental health benefits until demonstrated to be actuarially necessary.

b. This rule applies to:

1. Group health benefit plans issued by any and all insurers transacting the business of insurance under W. Va. Code §§33-16-1 et seq. and 33-25A-1 et seq., or who are otherwise subject to W. Va. Code §33-16-3a.

2. Individual subscribers and members and to all group members of a health benefit plan.

3. Group health benefit plans which begin on or after the first day of January, 2003. The provision of this rule shall cease to be effective on and after the thirty-first day of March, 2007, unless further extended by the Legislature.

c. This rule does not apply to any policy of individual accident and sickness insurance issued in accordance with article fifteen of chapter thirty-three of the W. Va. Code. (W.Va. Code §§33-15-1, et seq.).

1.2. Authority. -- W. Va. Code §§33-2-10 and 33-16-3a.

1.3. Filing Date. -- April 3, 2003.

1.4. Effective Date. -- April 3, 2003.

§114-64-2. Definitions.

2.1. "Additional cost containment measures" means relief provided to a group health plan after it has actuarially demonstrated to the commissioner that its total anticipated costs for the first year, or the total costs for every year thereafter for treatment of mental illness for any plan will exceed or will have exceeded two percent, or one percent for any group with twenty-five members or less.

2.2. "Commissioner" means the West Virginia insurance commissioner.

2.3. "Base period" means the period used to calculate whether the insurer may claim the two percent or one percent increased cost exemption. The base period must be twelve consecutive calendar months ending on or about sixty days preceding the next filing of the application.

2.4. "Claims" means, for purposes of this rule, requests for reimbursement for payment of services made by or on behalf of an insured to an insurer or a provider to an insurer, or its intermediary, administrator or representative.

2.5. "Diagnostic codes" means a numerical identifier as set forth in the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised.

2.6. "Diagnostic related groups" means a numerical code method of determining financing to reimburse various providers for services performed. A diagnostic related group is associated with a method of classifying inpatient hospital services published in the Federal Register.

2.7. "Group members" means beneficiaries or members receiving health care coverage through a group health benefit plan.

2.8. "Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate, hospital,

medical or health service corporation contract, health maintenance organization contract, or plan provided by a multiple-employer trust or multiple-employer welfare arrangement. "Health benefit plan" does not include excepted benefits as defined by W.Va. Code §33-16-1a (f).

2.9. "Incurred expenditures" means costs associated with mental health benefits and medical-surgical benefits. Incurred expenditures include actual claims paid and that percentage of per member per month case management expenses, administrative expenses, utilization review and capitation paid associated with mental health benefits during the base period. The allowable percentage is to be calculated by comparing actual amounts paid to providers per the terms of the health benefit plan or provider agreement for mental illness with the actual amounts paid to providers per the terms of the health benefit plan or provider agreement for all claims. Incurred expenses do not include premiums.

2.10. "Individual subscribers and members" means a single participant in a group health benefit plan.

2.11. "Insurer" means, for purposes of this rule, an insurer licensed to transact accident and sickness insurance in this state, and a health maintenance organization to whom a certificate of authority has been issued by the West Virginia Insurance Commissioner under the provisions of W. Va. Code §§33-16-1 et seq. and 33-25a-1 et seq., or who are otherwise subject to W. Va. Code §33-16-3a.

2.12. "Mental illness" means, for purposes of this rule, any illness or treatment that is specified as related to mental health in the form of diagnostic related groups, diagnostic codes, pharmaceutical and/or therapeutic classes.

2.13. "Pharmaceutical classes" means a numerical identifier of pharmaceuticals as set forth in the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, under the following classifications, as periodically revised: antianxiety and sedative-hypnotic drugs, antimania drugs, antidepressants, antipsychotics, CNS stimulants, alcohol antagonists and antidementia drugs.

2.14. "Plan" means, for purposes of this rule, filings consisting of each form offered for any group with more than twenty-five members. For groups with twenty-five members or less, filings may consist of each form offered or of that form offered as a group plan of twenty-five members or less.

2.15. "Serious mental illness" means an illness included in the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other

psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; and (vi) anorexia and bulimia.

2.16. "Therapeutic classes" means a numerical identifier of therapeutic treatments as set forth in the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised.

2.17. "Total anticipated costs" means all costs anticipated to be associated with implementing mental health parity, including actual claims paid and that percentage of per member per month case management expenses, administrative expenses, utilization review and capitation paid associated with mental health benefits during the base period. The allowable percentage is to be calculated by comparing actual amounts paid to providers per the terms of the health benefit plan or provider agreement for mental illness with the actual amounts paid to providers per the terms of the health benefit plan or provider agreement for all claims.

2.18. "Total costs" means all costs associated with implementing and transacting a health benefit plan, including both mental health benefits and medical-surgical benefits, including actual claims paid, and that percentage of per member per month case management expenses, administrative expenses, utilization review and capitation paid associated with mental health benefits during the base period. The allowable percentage is to be calculated by comparing actual amounts paid to providers per the terms of the health benefit plan or provider agreement for mental illness with the actual amounts paid to providers per the terms of the health benefit plan or provider agreement for all claims.

§114-64-3. Providing Benefits for Serious Mental Illness.

3.1. Each health benefit plan issued by an insurer shall provide benefits to all individual subscribers and members and to all group members for expenses arising from the treatment of serious mental illness. The expenses shall not include custodial care, residential care or schooling.

3.2 An insurer shall not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan.

3.3 An insurer may make determinations of medical necessity and appropriateness, and may use health care quality and management tools, which may include but are not limited to utilization review, use of provider networks, implementation of cost containment measures, pre-authorization for certain treatments, setting coverage levels, including the number of visits in a given time period, using capitated benefit arrangements, using fee for service arrangements, using third party administrators and using patient cost sharing in the form of copayments,

deductibles and coinsurance.

§114-64-4. Allowance of Additional Cost Containment Measures.

4.1. An insurer may apply additional cost containment measures, upon approval of the commissioner, if the insurer submits actuarially certified information to the commissioner demonstrating that its total anticipated costs for the first year of implementation for treatment of mental illness for any plan will exceed two percent, or one percent for any group with twenty-five members or less, of the total costs for the plan. Each year thereafter the insurer submits actuarially certified information to the commissioner demonstrating its total costs for treatment of mental illness will exceed or have exceeded two percent, or one percent for any group with twenty-five members or less, for the plan in the base period.

a. Whether a treatment is, for purposes of this rule, a treatment for mental illness will be determined by inclusion of the treatment in the diagnostic response groups, diagnostic codes, pharmaceutical classes or therapeutic classes related to mental illness as determined by the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised.

b. If a treatment is included in one or more diagnostic related groups, diagnostic codes, pharmaceutical and/or therapeutic classes, it shall be included in the insurer's calculations and actuarial assessment for total anticipated costs.

4.2. The total anticipated costs must be based on actual claims data, and may not be based on an increase in insurance premiums.

§114-6-5. Calculation for Application of Additional Cost Containment Measures.

5.1. If an insurer anticipates that its total costs for treatment of mental illness for any plan will exceed or have exceeded two percent, or one percent for any group with twenty-five members or less, of the total costs for such plan in any base period, the following calculation shall be used as part of an application to implement cost containment measures intended by the insurer to maintain costs below the two percent or one percent of total costs threshold:

a. Total anticipated costs during the base period, for that plan, divided by

b. Total costs during the base period, for that plan.

§114-64-6. Aggregate Lifetime Limits.

6.1. An average aggregate lifetime limit may be imposed if the benefit categories to which separate limits apply account for at least one-third of the dollar amount of all plan payments for medical-surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third of the dollar amount of all plan payments for medical-surgical benefits.

§114-64-7. Annual Limits.

7.1. An average annual limit may be imposed if the benefit categories to which separate limits apply account for at least one-third of the dollar amount of all plan payments for medical-surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third of the dollar amount of all plan payments for medical-surgical benefits.

§114-64-8. Rates and Forms Filings.

8.1. Insurers that anticipate total costs exceeding two percent, or exceeding one percent for groups of twenty-five members or less, shall file an application containing actuarially certified data with the Rates and Forms Division, West Virginia Insurance Commission to be qualified to implement any costs containment measures that may be applicable.

8.2. The actuarially certified application shall be filed no less than sixty days before the anticipated effective date or renewal date of the plan.

8.3. The commissioner shall have sixty days within which to approve or disapprove the use of cost containment measures.

8.4. The approval of additional cost containment measures shall be on an annual basis and may result in a directive to add or delete cost containment measures.

8.5. Each insurer shall file an annual report, on a form prescribed by the commissioner, regarding the fiscal impact of mental health parity expenses on their budgets for the preceding year.

8.6. An insurer shall make available a summary of the data and the computation supporting the anticipated costs of mental health parity and anticipated total costs must be made available to plan participants and beneficiaries, free of charge, upon the written request of the participant or beneficiary.

§114-64-9. Coverage for Alcohol Treatment.

Coverage for alcohol treatment shall be included in mental health treatment. Any other language restricting alcohol treatment coverage, including that found in W.Va. Code §33-16-3c, is superseded by W. Va. Code §33-16-3a.